



*(Signature, Sidney)
224797*

INFIRMARY NURSING PROGRESS NOTES

Date/Time

4/18/06 9 AM Back R/C
 811
 9 Cervical to lower Back.
 DTR - ev
 No awareness.
 Heart PM
 EKG
 1/18 Back R/C
 Powell, J. ADW/P Sx

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
-----------------------------------	------	-----	-----	-----

Date/Time	Inmate's Name:	D.O.B.
3-30-06	Clayton Sines	3 123, 76
	wt 189, 198 ⁸⁰ , B/P 128/80 R20, 02 98%, P 76	
	40 Sineses 1 ① 750, ② 450 ③ 500	
O)	Yellow Spots not plaque lender from sites frontal & - other Site normal Lungs Abd. Rhonchi Wild Exp. Wheez +	
	AB - NL -	
	CW - NBR	
	Abd. Soft NT	
(A)	Asthma -	
	nonCompliance -	
	no evidence of Bact malice - clinically	
(P)	Cont Humid - Frontal lab GM	
(E)	comply	
4/1/06	9 here for Raylocy	
	9 apparent poor vision	
	App will for Raylocy Uniflsee by eye doctor	



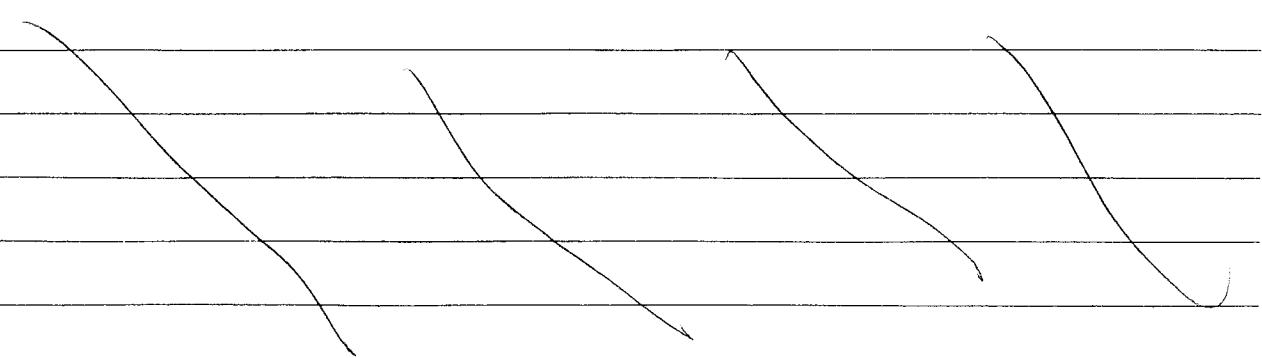
PRISON
HEALTH
SERVICES
INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name:	Clayton Sidney #22477	D.O.B.:
3/17/06 0803	D.O.B.: 03/23/76		
	Referral from MS Glorid R/T who is wheezing		
	Wt 192 lbs O ₂ Sat 98% P66 BP 140/60 T98.6 R-20		
	S & B - or op		
(R)	Bil Rhonchi	—	Has previous Hx
	no wheezing mild R/T	—	wheezing
	Lung CTA	—	
	CV-NFR	—	
(A)	mild - exacerbation of asthma asthma	—	
(P)	jet neb	—	
	Humidifier	—	
	prednisone	—	
(E)	Report NSU — and FOB	—	<u>R</u>
<p>3-24-06 wt 192, P 98, O₂ sat 96%, T 98.8, R 18, BP 140/60 Peak flow ① 550, ② 450, 3300</p>			
O)	Bs Normal -	—	
	Bil. Rhonchi -	—	
	Non-Compliant -	—	
(A)	Resolving asthma Exacerbation. (mild)	—	
(P)	Cont Rx	—	
(E)	Comply	—	<u>R</u>

Date/Time	Inmate's Name:	D.O.B.:
3.15.06	Clayton, Sidney 234797 Wt. 191 P 65 T 98 B/p $\frac{122}{78}$ R $\frac{122}{78}$ 025at 98%	3123176

CRNP request to see 29 BM for flu? Saw DR 1-3-06 clo back pain and request for BB - denied
 Based on physical finding by no report on BB today
 S profile I fear it will be removed by Doc x-ray 12/6/05
 result w/ normal impression of radiologist
 No US on back S Dif. ably removes
 Shows S difficulty pulls shirt up over shoulder
 S any difficulty noted today
 Plans on test
 MS - spinal process w/L Omoses 2+ to
 palp & bruises & cuts From
 Ext OECC From muscle strength 44 B.I.R.
 reflex 2+ B.I. PI 2+ DP 2+ B.I. SLR OROK
 A normal Physical exam
 Safety to exercise/walk Bunk at knees to
 pick up w/ no exercise as selected not to do
 BACK exercise as DR recommended
 instructed to use ladder bars at end of bunk
 for climbing & not to avoid jumping down from
 bunk RTK Pnw Haze and





PROGRESS NOTES

Date/Time	Inmate's Name:	224797 D.O.B.: 3/23/76
(-3-06)	WT 192 T 56 ⁸ P 80 R 20 B/p 150/100	
O)	Might Remove Shoes easily undressed — Shoulders - ROM - LS spine - Flex - Full ROM	
	NT - no deformity → Ext & Sce	
	No motor deficit -	
(A)	Malingering No need for PT - denied -	
P)	Back Exercises	Monte BP
(S)	Comply	/



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
2.7.05	Clayton, Sidney 224797	3 123 176
	188 wt. P103 T96.8 B1/p ¹¹⁰ /70 R/S	
	% back pain / Shawing Profile/weight loss	
O)	Exaggerating Symptoms	
	Tender <u>mildly</u>	
	Thoracic area —	
	WT - LS - spine area —	
	No new s	
	No swelling	
	ROM normal	
	Ex left the back	
	other MS exams n/c	
(A)	back sprain	
	no any #	
P)	XR —	
	Pending	
(S)	Complaints	
	<u>f</u>	

Date/Time	Inmate's Name:	D.O.B.:		
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12-20-05	WT 192 P 60 T 96.8 B/p 133/70 R 20 C/S back pain			
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L S Spine

This inmate is

C)

Rare NL

Extremely manipulative,

NT

Malingering - and

no fretting

Seeking protest to

Create trouble to himself

(A) Normal LS -

and others

(P) Back Exerciser — no need for N.S.A.D.s - h

(E) Regular Exerciser —

x R- Reviewed

h

NL -

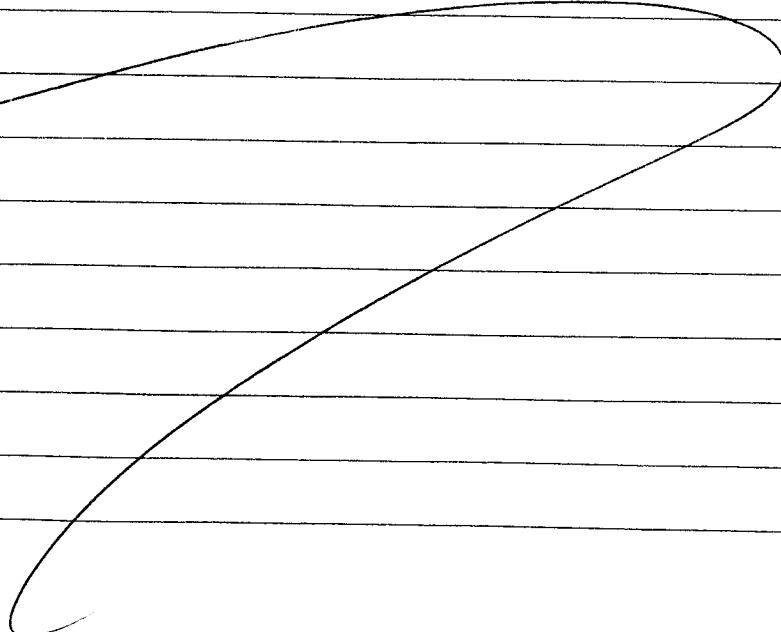
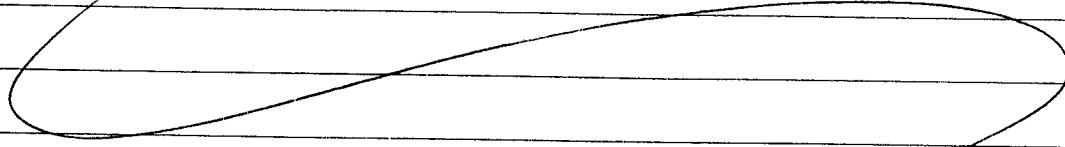
Addendum —

clinical

No evidence of any C/S pain in any where

a rest - Counseling may Benefit

h



Date/Time	Inmate's Name:	D.O.B.:
12/06/06	Clayton Soddy	/ /
	WT. 186 H.P. 112/62 P. 60, T. 982 R. 20 O 2 98	
	S) I'm hurting in my back	
(o)	able to remove clothes there are no problem	
	Smiles at Time	Walking well-
	Walking	
	able to shake both shoulders -	
	M.S. System -	no vomitings
	all joints ROM NL	
	Tender over Thoracic spine	
	L5-Sacral +	
	NO swelling	
	IM Exaggerating / malingering	
	Said to have fallen on Toilet	
(A)	no # spine	
(P)	XR	
	N/Luds -	
(S)	most best	
	<i>L</i>	



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
12-05-05	Clayton Sidney	3 123176
	wt. 186. f 72 T 99.8 B/P 122/88 R 20	
	Yo Nausea/Vomiting dizziness Hepatitis Fainting Spell	
O)	NO Vomiting — to-day are Yesterday	
O)	Tender over Lungs — Cong. Nasal secretions — Abd. Soft & NT no palpable masses	
(A)	Sinusitis Allergic — c rhinorrhea dizziness aching — in leg	
O)	Thrombocytopenia Hematuria	
(E)	Reg. Wright f	



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
10/20/05	Clayton, Sidney Wt. 192# P68 T97.4 B/p 118/80 R 20 C/S sinus	/ /
	(A) Cong Nasal Mucosa — Tender over frontal sinuses Turbinates mildly hypertrophied	
	(A) Chr Allergic Sinusitis	
	(P) CTH	
	(E) Emphysema	
11/30/05	Wt. 189 P59 T98.8 B/p 118/80 R 18 C/S He wants to be tested for Hepatitis B Vac	
	(O) Never Blood Transfusion / Tattoo X Drug abuse X Cocaine / Meeds —	
	P/E. Normal — X Liver Enlargement NT —	
(A)	Answered. At this time unlikely to have hepatitis.	
(P)	At this time medically not necessary to do Lab	
(E)	No Risk factors or clinical correlation	

Date/Time	Inmate's Name:	Prisoner, Joseph #324794 End Q.B.: 1 1
9/14/05	Wt. 189# B/p 120/82, P76 R18 T 98.4	
	(C/O sinus congestion) I'm Clayton Sedney 3/23/	
	29 Bm pr cb As above x 3 yrs HIS # 224797	
	C reported watery eyes, sneezing & runny nose	
	TAB US2 AAOX3	TMVSA
	HEENT fm's intact nose throat clear c shiny clear axillae & throat note! Oropharynx lymph nodes tend to palp & appetite Lung cb	
A	acute allergic sinusitis	Non smoker
P	Sudafed TI po B10X (week)	
P/E	Cough has ipox 10 days ctm TI po B10X for 1 week Doxycycline 100mg TI po B10X 1 week Flu. Compilance & meds Rte raw Hayl cold	

10/3/05-9:25am Wt. 188# P56 T 96.8 B/p 138/80 R 28
C/O Sinus

O) No change -

(A) Mild allergy

(P) Constipation

(E) Reg. Exercise



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
12/16/03	Clayton, Sidney	/ /
12/16/03 S 27yo BM wants to renew shaving profile ONAD noted: face clear - few old scars, mild discoloration. 4 papules/pustules A Chronic faciae folliculitis P Renew profile x 6mo — Oldley CRW 6-18-04 WT 217 BP 140/100 P 69 R 20 T 98.8 11/20 S " renew shave profile" — Macneill ST few follicles - scattered (A) Sp - mild facial folliculitis (P) Sp - 6mo — Signature		
12/17/04 1105	WT 206 3/4 lbs T 97.8 P 68 Pulse ox 98% BP 140/100 Renewal of shaving profile	
(P)	mild facial folliculitis	
(A)	facial folliculitis	
(P)	Sp	
(S)	Exercise	<i>Signature</i>



EMERGENCY

ADMISSION DATE 7/13/06	TIME 8 AM	ORIGINATING FACILITY BCCF	<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT					
ALLERGIES NIKA	CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input checked="" type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA							
VITAL SIGNS: TEMP 98.6	ORAL RECTAL	RESP 18	PULSE 98 B/P 122/9 RECHECK IF SYSTOLIC <100> 50					
NATURE OF INJURY OR ILLNESS <p>S. Soft ball hit my leg</p> <p>O. 30 y/o Blm to LCCs ambulatory and lab no wat swelling to leg She's remain in fact She's w/o to touch deep l ear</p> <p>A. Alibrator is comfort</p> <p>P. Referred to Doc</p>	<table border="1"> <tr> <td>ABRASION //</td> <td>CONTUSION #</td> <td>BURN XX XX</td> <td>FRACTURE Z Z</td> <td>LACERATION / SUTURES</td> </tr> </table> <p>PROFILE RIGHT OR LEFT</p> <p>RIGHT OR LEFT</p>			ABRASION //	CONTUSION #	BURN XX XX	FRACTURE Z Z	LACERATION / SUTURES
ABRASION //	CONTUSION #	BURN XX XX	FRACTURE Z Z	LACERATION / SUTURES				
PHYSICAL EXAMINATION								
DIAGNOSIS								
INSTRUCTIONS TO PATIENT If condition worsens return to see MD								
DISCHARGE DATE 7/13/06	TIME 8:03 AM	RELEASE / TRANSFERRED TO DOC	CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL					
NURSE'S SIGNATURE J. DuBois	DATE 7/13/06	PHYSICIAN'S SIGNATURE PC 7/13/06	CONSULTATION					
INMATE NAME (LAST, FIRST, MIDDLE) Clayton, Sidney	DOC# 224797	DOB 3/13/76	R/S PM	FAC BCCF				



DEPARTMENT OF CORRECTIONS

TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: BCCFDate: 4/24/06 Time: 11:00 AM/PM

RECEIVED FROM:

Institution/Work Release Center/Free-World Hospital

RELEASED: Inmate/Health Record

Institution: VCFDate: 4-10-06 Time: 11:00 AM/PM

RELEASE FROM:

- Infirmary Segregation
 Population Mental Health
 Other

ALLERGIES:

NKA

PHYSICAL EXAMINATION

Date of last exam: 3-7-06

Chest X-Ray Date: _____ Result: _____

PPD Reading: 5

Classification: _____

Limitations: _____

RECEIVING MEDICAL STATUS

- Population
 Infirmary
 Isolation

RELEASE TO:

- DOC Infirmary Mental Health
 Other

Institution/Work Release Center/Free-World Hospital

LAB RESULTS - LAST REPORT

Date

Normal

Abnormal

YES

NO

CBC

Wears Glasses/Contacts

Urinalysis

Dental Prosthesis

Hearing Aide

Other Prosthesis

W. DalsorReceiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

Asthma (mild)

CURRENT MEDICATION, DOSAGE AND FREQUENCY

Piroxicam Tab 4 mg po BID
x 14 days
Harmacard 600 mg po BID
CTM 8 mg po QD x 14 days

- MEDICATIONS Sent w / inmate Not sent w / inmate
 X-RAY FILM Sent w / inmate Not sent w / inmate
 HEALTH RECORD Sent w / inmate Not sent w / inmate
 Released to: W. Dalsor

Date: _____ Time: _____ AM/PM

- MEDICATIONS Received Not Received
 X-RAY FILM Received Not Received
 HEALTH RECORD Received Not Received
 CHART REVIEWED YES NO
 Received by: W. Dalsor
 Signature of Receiving Nurse

Date: _____ Time: _____ AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: _____ LAST CLINIC: _____

FOLLOW-UP CARE NEEDED Date Time With Whom - Location (Sending Nurse) Date/Appt Made w/Whom (Rec. Nurse)

 Medical Dental Mental HealthNURSING ASSESSMENT (SENDING NURSE)
(Noted from health record documentation)

	Yes	No
Drug Use	/	/
Mental Illness	/	/
Suicide Attempt	/	/
Chronic Care	/	/

	Yes	No
Special Diet	/	/
Appearance	/	/

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)
(Noted from inmate assessment)

	Yes	No
SKIN	Open Sores	/
	Lice	/
	Edema	/
	Warm & Dry	/
	Cool & Moist	/

	Yes	No
CONDITION	Alert	/
	Oriented	/
	Uncooperative	/
	Depressed	/

Sick Call Procedures Explained

yes

Height

6'3

Weight

Blood Pressure

Temperature

Pulse Resp

98

Other

78/18

Signature of Nurse Completing Assessment (Sending Nurse)

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST, FIRST, MIDDLE)

Clayton SidneyDOC# 224797DOB 3-23-76Race/Sex B/nFAC VCF

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Marcus J. Sedley
LAST FIRST MI

DATE OF BIRTH 5-23-76 SS# 224197

Housing Recommendations:

General Population _____

Medical Observation Unit _____

Lower Level/Lower Bunk _____

Suicide Precautions _____

Special Watch (15 Minute Checks) _____

Isolation _____

Initiate Universal Precautions _____

Individual found to be:

Frail/Elderly _____

Physically Handicapped _____

Developmentally Disabled _____

Drug/Alcohol Withdrawal _____

Special Mental Health Needs _____

Expressed Suicidal Ideation _____

History of Seizures _____

Other _____

Specify _____

Nurse Debra L. S. Date 12-04-06

Debra L. S. 12-04-06



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton-Bey Date of Request: 4/24/06
 ID # 224797 Date of Birth: 3/23/76 Location: 26-12
 Nature of problem or request: My Kop Sinus medicine has run out. I can't sleep right because of my aggravated Sinus. (Note) This is to follow up on treatment.

Sidney Clayton-Bey
 Signature

DO NOT WRITE BELOW THIS LINE

Date: ___ / ___ / ___

Time: _____ AM PM

Allergies: _____

RECEIVED

Date: _____

Time: _____

Receiving Nurse Initials _____

(S)ubjective:

(O)bjective

(A)sessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Clayton Sidney

Inmate Number: 224797^{ext}First Date of Birth: 3 12 31 76^{MM DD YYYY}Date of Report: 1 / 1 / ^{YY}

Time Seen: AM / PM Crd Date

Subjective: Chief Complaint(s): Back pain (Chronic) Problem with feet need
Onset: Something bad. Support. Severe problem

Brief History: Was taking CTM that was helping also
(Continue on back if necessary)
I would like extra Motrin

Objective: Vital Signs: (As Indicated) T: 97.8 P: 80 RR: 18 BP: 120/80 WT 198

Examination Findings:
(Continue on back if necessary)

Check here if additional notes on back

Assessment: (Referral Status)

Referral NOT REQUIRED

Preliminary Determination(s):

Check here if additional notes on back

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: _____

OTC Medications given (^{Describe}) NO YES (If Yes List):

Referral: NO YES (If Yes, Whom/Where): Dr. Seddeg

Date for referral: 4/14/06
^{MM DD YYYY}

Referral Type: Routine Urgent Emergent (If emergent who was contacted): _____

Time _____

L. Anderson
Nurses Signature

Name: _____

Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton Date of Request: 4/12/06
 ID # 224797 Date of Birth: 3/23/76 Location: 20 12 B

Nature of problem or request: I'm being having back problems, feet problems, and my sinus are acting up.

Sidney Clayton
 Signature

DO NOT WRITE BELOW THIS LINE

Date: ____ / ____ / ____

Time: _____ AM PM

Allergies: _____

RECEIVED

Date: _____

Time: _____

Receiving Nurse Initials _____

(S)ubjective:

(O)bjective

(A)sessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name:

Sidney Dayton

Date of Request:

4/10/06

ID #

28477

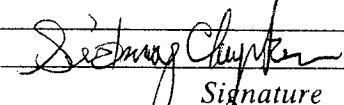
Date of Birth:

3/23/76

Location:

2012B

Nature of problem or request:

I can't see to well I need my key lock.


Signature
DO NOT WRITE BELOW THIS LINEDate: *4/12/06*

Time: _____ AM PM

Allergies: *NKDA*

RECEIVED

Date: *4/12/06*Time: *0745*Receiving Nurse Initials *Ja***(S)ubjective:****(O)bjective (V/S):***T: 98.2**P: 80**R: 18**BP: 130/72**WT:***(A)sessment:****(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY If Emergency was PHS supervisor notified: Yes No Was MD/PA on call notified: Yes No **SIGNATURE AND TITLE**

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

**PROGRESS NOTES****Date/Time****Inmate's Name:** Clayton, Sidney 224797 D.O.B.: 3/23/76

4/1/06 8:45

Rec'd today @ Bullock c & ol I of I. Had 2 meals
and 2 mar jackets was left in Nursing station. —

J Howard Mec-



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Sidney Clayton Date of Request: 3/28/06
 ID # 224747 Date of Birth: 3/22/76 Location: Seg 804
 Nature of problem or request: My sinuses are acting up again. This is a recurring sickness.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/29/06.
 Time: 9:30 AM PM
 Allergies: NKA.

RECEIVED
 Date: 3/29/06
 Time: 9:30
 Receiving Nurse Initials DS

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment: See Ref to all.

(P)lan: Refer to MD. 3-30-06 @ 10am -

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

J. O'Brien
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS

Upper Respiratory Complaints

Facility: Ventress Correctional Facility	Sidney
Patient Name: Clayton	
Inmate Number: 224797	Date of Birth: 3 12 31 76
Date of Report: 3 29 06	Time Seen: 3:30 AM/PM

Subjective: Chief Complaint(s): Runny/Stuffy Nose Sneezing Sore Throat Swollen Glands Headache Fever
 (Check All That Apply)
 Malaise Earache Cough: No Yes: Non-productive Productive: (sputum description):
 Other: Colder air Yes.

Onset: 1 hr ago
 History: (Go that evening on yard for walk after meal) History of Asthma: No Yes
 (Continue on back if necessary)

Objective: Vital Signs: (If Indicated) T: 98.8 P: 22 RR: 18 B/P: 130 / 90
 Cardiac/CHF history: No Yes
 History of HIV Disease: No Yes
 Eyes: Clear Watery Injected (red) Drainage: No Yes:
 Nose: Congestion: No Yes Drainage: No Yes:
 Throat examination: Normal Red Enlarged tonsils Edematous
 Neck: Normal Enlarged Lymph Nodes

Additional Examination
 Continue on back if necessary
Wt 171 lbs dat 9/79. running on crackles noted.

Check Here if additional notes on back

Lung sounds:

- | | |
|-------------------------------------|-------------------------------|
| <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Clear | <input type="checkbox"/> |
| <input type="checkbox"/> Diminished | <input type="checkbox"/> |
| <input type="checkbox"/> Crackles | <input type="checkbox"/> |
| <input type="checkbox"/> Rhonchi | <input type="checkbox"/> |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> |

Assessment: (Referral Status)

Referral NOT Required

Referral Required referral due to the following: (Check all that apply)
 Abnormal Vital Signs Inability to swallow Significant shortness of breath
 Abnormal Lung exam Significant Wheezing which does not improve with inhaler

Recurrent Complaint (More than 2 visits)
 Other: _____

Preliminary Determination(s): Off my heart comfort.

Off. Dr. Dennis

Check Here if continued on back

Plan: Check All That Apply:

- Advise rest and oral fluid intake Warm saline gargles PRN
- If no referral is made, advise to return in 3 - 5 days if symptoms have not resolved
- Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)
- Other: _____ (Describe)

OTC Medications given NO YES (If Yes List)

Referral: NO YES (If Yes, Whom/Where) Dr. Payapati Date for referral: 3 29 06
 MM DD YY

Referral Type Routine Urgent Emergent (if emergent who was contacted?)

Time _____

J. Odis, RN
 Nurses Signature

Name:

J. Odis, RN
 Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton Date of Request: 3/22/06
 ID # 224797 Date of Birth: 3/23/76 Location: 9A SB

Nature of problem or request: I'm requesting to get to a non smoking facility MT. Drawton. She has no problem with it as long as the Doctor approves it. I'm on medics and a breathing machine for my asthma

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/22/06
 Time: 1:50 AM PM
 Allergies: NKA

RECEIVED
Date:
Time:
Receiving Nurse Initials _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)sessment:

See Det. tool

(P)lan: Report to HCC on Friday 3-24-06 @ 9am
for app't. c MD.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

Kelvin
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: ClaytonSidneyInmate Number: 224797First Date of Birth: 3 123,76
MM DD YYYYDate of Report: 3 122,06
MM DD YYYYTime Seen: 1:50 AM PM Circle One

Subjective: Chief Complaint(s): Smoke from outside bothers me.
Onset: few weeks time.

Brief History: Smoke to H.S.A. Concerning problem. Advised to report to S.C. Slip Shop to see Dr. And Dr. if some thing can be done.

Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98.8 P: 73 RR: 8 B/P: 110 180

Examination Findings: At 197 lbs. O2 sat 97% by pulse oximetry. Muffled voice heard on inhalation and expiration. Has been taking Fr. Tx & 7 days. Last Tx was 5 am 3 hrs ago. pt had dry cough. No teal as being given except for a few classes.

Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): Clt. in goes to change R.R. Smoke irritation
 Referral NOT REQUIRED
 Referral REQUIRED due to the following: (Check all that apply)
 Recurrent Complaint (More than 2 visits for the same complaint)
 Other: evaluate.

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

- Instructions to return if condition worsens.
- Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)
- Other: _____

(Describe)

OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, Whom/Where): Dw. Rayapati

Date for referrals: 3 24 06
MM DD YYYY
Time _____

Referral Type: Routine Urgent Emergent (if emergent who was contacted?)

X J. Atis, RN
Nurses Signature

Name: J. Atis, RN

Printed



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Sidney Clayton Date of Request: 3/16/06
 ID # 224797 Date of Birth: 3/23/76 Location: 9A SB
 Nature of problem or request: The Smoke out Side is bothering me.
It is hard for me to breathe, and I'm getting dizzy.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/22/06
 Time: 1:50 AM PM
 Allergies: NKDA

RECEIVED
 Date: 3/17/06
 Time: 9:00
 Receiving Nurse Initials: DS

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)sessment:

See next tool

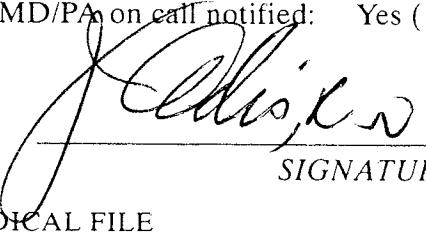
(P)lan: Report to HCs Friday 3-24-06 @ 9 am.
for appt C.M.D.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No


SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Facility: VENTRESS

Patient Name: Clayton

Inmate Number: 224797 Last

Date of Report: 01/03/2006

Sidney

First Date of Birth: 13, 23, 76 MI

Time Seen: 0925 AM / PM Circle One

MM DD YYYY

Subjective: Chief Complaint(s): Back pain

Onset: When I tried to get on top rack

 New onset Chronic condition exacerbationPain Scale: (1-10) 5 Type: Sharp Dull Intermittent ConstantNumbness: No YesLocation of Pain: lower back Radiation of pain: No Yes to: _____
Neck / mid-back / low backHistory: didn't have any back problems until I was
(Continue on back if necessary)
enough and I passed out and hit the tail stand Check Here if additional notes on backAssociated symptoms: Pain on urination? No Yes Nausea No Yes Vomiting No Yes (x)
Increased urination? No Yes Pain with cough/breathing? No Yes**Objective:** Vital Signs: (If Indicated) T: 96 P: 80 RR: 20 B/P: 150 / 100Back Exam: Tender to touch Contusion Muscle spasms Impaired range of motionAdditional Findings: Numbness Tingling Abnormal gait Weakness of extremities Foot drop Other:

Elaborate positive findings: inmate states "I just can't do any climbing"

 Check Here if additional notes on backLower extremities: Normal Abnormal (Describe): _____Pedal pulses: Present Absent Additional Examination:

(Continue on back if necessary)

 Check Here if continued on back**Assessment: (Referral Status)**

Preliminary Determination(s): _____

 Referral NOT Required Referral Required due to the following: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Loss of sensation | <input type="checkbox"/> Presence of RBCs from dipstick | <input type="checkbox"/> Recurrent Complaint (More than 2 visits for the same complaint) |
| <input type="checkbox"/> Prior malignancy | <input type="checkbox"/> Presence of WBCs from dipstick | |
| <input type="checkbox"/> Other: _____ | | |

Plan:Check All That Apply: Work and recreation restrictions x 72 hours Education on avoiding back pain Education about stretching and back exercises. Instructions to return if condition worsens. Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits) Other: _____

(Describe)

 Cold Compress (Acute injury) Warm Compress OTC Medications given NO YES (If Yes List): _____Referral: NO YES (If Yes, Whom/Where): _____ Date for referral: / /
MM DD YYYYReferral Type: Routine Urgent Emergent (if emergent who was contacted?): _____ Time _____x Maverine Benefield
Nurses SignatureName: Maverine Benefield Jr
Printed



PRISON HEALTH SERVICES, INC.

SICK CALL REQUEST

Print Name: Sidney Dayton

Date of Request: 1-3-08

ID # 224747

Date of Birth: 3/23/76 Location: 9A 5T

Nature of problem or request: My duck is hurting. I can't get on a perch.

Sidney Dayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: _____ / _____ / _____

Time: _____ AM PM

Allergies: _____

RECEIVED

Date: 1-3-04

Time: q' \rightarrow

Receiving Nurse Initials DS

(S)ubjective:

(O)bjective **(V/S)**: T: P: R: BP: WT:

(A)ssessment:

(P)Namp;

Seen per MD today 1-3-06.
Release of liability signed.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

Hunter, LPN

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: S. Breyer Clayton Date of Request: 1-3-06
 ID # 224747 Date of Birth: 3/23/76 Location: 9A ST
 Nature of problem or request: My back is hurting. I can't get on
a sprain.

S. Breyer Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 1-3-06

Time: AM PM

Allergies:

RECEIVED

Date: 1-3-06

Time: 9:00

Receiving Nurse Initials DS

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)sessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

Chetler L.W.

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON
HEALTH
SERVICES
INCORPORATED

224797

RELEASE OF RESPONSIBILITY

Inmate's Name: Clayton, Sidney 224

Date of Birth: 3-23-76 Social Security No.: _____

Date: 1-2-06 Time: 1930 A.M.
P.M.

This is to certify that I, Clayton, Sidney
(Print Inmate's Name), currently in
 custody at the Ventress Correctional Facility
(Print Facility's Name), am refusing to
 accept the following treatment/recommendations: Keep Sick call appt
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Sidney Clayton 224797

(Signature of Inmate)**

H. Johnson LPN

(Signature of Medical Person)

Yolanda Masayh

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Sidney Clayton Date of Request: 1-1-06
 ID # 224797 Date of Birth: 3/27/76 Location: 6B
 Nature of problem or request: My back P's still bothering me. I need to see the doctor about a bottom bunk profile.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 1/1/06
 Time: 1930 AM PM
 Allergies: None

RECEIVED	
Date:	<u>1/2/06</u>
Time:	<u>1930</u>
Receiving Nurse Initials <u>JG</u>	

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)sessment:

Waver signed

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()
 Was MD/PA on call notified: Yes () No ()

G Johnson RN

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

Back Pain

Facility: VENTRESS	Clayton	Sidney
Patient Name:		
Inmate Number:	824797	First Date of Birth: 3 12 31 76 MI
Date of Report:	12 18 05	Time Seen: 0830 AM / PM Circle One

Subjective: Chief Complaint(s): *✓ back pain*

Onset: 12-05-05

New onset Chronic condition exacerbation

Pain Scale: (1-10) 7 Type: Sharp Dull Intermittent Constant Numbness: No, Yes

Location of Pain: ✓ Back Radiation of pain: No Yes to: _____

Neck/mid-back / low back

History: *Cb & back pain on 12-05-05, continue off analon*

(Continue on back if necessary)

Check Here if additional notes on back

Associated symptoms: Pain on urination? No Yes Nausea No Yes Vomiting No Yes (x)

Increased urination? No Yes Pain with cough/breathing? No Yes

Objective: Vital Signs: (If Indicated) T: 97.8 P: 12 RR: 18 B/P: 110 / 80

Back Exam: Tender to touch Contusion Muscle spasms Impaired range of motion

Additional Findings: Numbness Tingling Abnormal gait Weakness of extremities Foot drop Other: _____

Elaborate positive findings: _____

Lower extremities: Normal Abnormal (Describe): _____ Check Here if additional notes on back

Pedal pulses: Present Faint Absent

Additional Examination: _____
(Continue on back if necessary)

Assessment: (Referral Status)

Referral NOT Required

Referral Required due to the following: (Check all that apply)

Loss of sensation Presence of RBCs from dipstick Recurrent Complaint (More than 2 visits for the same complaint)

Prior malignancy Presence of WBCs from dipstick

Other: _____

Preliminary Determination(s): *Confort lumbalg* Check Here if continued on back

Plan:

Check All That Apply: Work and recreation restrictions x 72 hours

Education on avoiding back pain Education about stretching and back exercises Instructions to return if condition worsens

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: _____ (Describe)

Cold Compress (Acute injury) Warm Compress

OTC Medications given NO YES (If Yes List): *Motrin 600 mg po TID x 7d*

Referral: NO YES (If Yes, Whom/Where): *Dr Ryapati* Date for referral: 12/18/05
MM DD YYYY

Referral Type: Routine Urgent Emergent (if emergent who was contacted?): _____ Time _____

x *A Marsh fm* Name: *A Marsh fm*

Nurses Signature

Printed



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Sidney Dayton Date of Request: 12/16/05
 ID # 224797 Date of Birth: 3/23/76 Location: 6Dor in Seg 608
 Nature of problem or request: My back is in pain. I need something
Seg. 608 for pain!

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 12/18/05
 Time: AM PM
 Allergies: WHD4

RECEIVED	
Date:	<u>12-18-05</u>
Time:	<u>08:00</u>
Receiving Nurse Initials <u>AM</u>	

(S)ubjective:

(O)bjective (V/S): T: 97.8 P: 72 R: 18 BP: 110/80 WT: _____

(A)ssessment:

(P)lan:

*See Dr Raypathi
12-20-05
8:00 am*

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

A. Mankin

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Sidney Clayton Date of Request: 12/15/05
 ID # 224797 Date of Birth: 3/23/76 Location: 6 Dorm Seg.
 Nature of problem or request: I have a bad cold. I'm also putting in a request to get my teeth cleaned by the dentist. My back is still hurting rest bed.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 12/16/05
 Time: 12:00 AM (PM)
 Allergies: NKA

RECEIVED
Date: <u>12/16/05</u>
Time: <u>9:00</u>
Receiving Nurse Initials <u>TDS</u>

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: 190

(A)sessment:

(P)lan: Cold treatment S. d/f f/d.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

J. Pedro D.N.
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

Upper Respiratory
Complaints

Facility: BBB
 Patient Name: Clayton
 Inmate Number: 224797
 Date of Report: 12/16/05
 MM DD YYYY

First Date of Birth: 3/23/76
 MM DD YYYY
 Time Seen: 12:00 AM / PM Circle One

Subjective: Chief Complaint(s): Runny/Stuffy Nose Sneezing Sore Throat Swollen Glands Headache Fever

(Check All That Apply)

Malaise Earache Cough: No Yes: Non-productive Productive: (sputum description): Yellowish
 Other: _____

Onset: _____

History: _____

(Continue on back if necessary)

History of Asthma: No YesCardiac/CHF history: No Yes Check Here if additional notes on back
History of HIV Disease: No YesObjective: Vital Signs: (If Indicated) T: 97.8 P: 76 RR: 20 B/P: 140 / 90Eyes: Clear Watery Injected (red) Drainage: No Yes: _____

Lung sounds:

Left

Clear

Diminished

Crackles

Rhonchi

Wheezing

Nose: Congestion: No Yes Drainage: No Yes: mucusThroat examination: Normal Red Enlarged tonsils EdematousNeck: Normal Enlarged Lymph Nodes Additional Examination:

(Continue on back if necessary)

no noted congestion, no drainageat this time.Assessment: (Referral Status) Referral NOT Required

Preliminary Determination(s):

 Check Here if continued on backalteration in health
subject. R/F Common Cold Referral Required referral due to the following: (Check all that apply)

Abnormal Vital Signs Inability to swallow Significant shortness of breath
 Abnormal Lung exam Significant Wheezing which does not improve with inhaler

 Recurrent Complaint (More than 2 visits) Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Advise rest and oral fluid intake Warm saline gargles PRN
 If no referral is made, advise to return in 3 - 5 days if symptoms have not resolved
 Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: Cold treatment 4 days See Doctor Sheet
 (Describe)

OTC Medications given NO YES (If Yes List): Cough tabs / Sudafed 60; CTM 11

Referral: NO YES (If Yes, Whom/Where): _____ Date for referral: / /
 MM DD YYYYReferral Type: Routine Urgent Emergent (if emergent who was contacted?): _____ Time _____

X _____

Nurses Signature

Name: _____

Printed



EMERGENCY

ADMISSION DATE 12/15/05	TIME 6:40 AM	ORIGINATING FACILITY VCF	<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT		
ALLERGIES NKDA	CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA				
VITAL SIGNS: TEMP 98	ORAL RECTAL	RESP 20	PULSE 87 B/P 120/84 RECHECK IF SYSTOLIC <100-50		
NATURE OF INJURY OR ILLNESS <p>(S) I fell and hurt my back. I feel a sharp pain in my back and I can't move.</p>	ABRASION //	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / SUTURES
<p>PROFILE RIGHT OR LEFT</p> <p>RIGHT OR LEFT</p>					
PHYSICAL EXAMINATION <p>(1) BM lying beside bunk in single cell in a supine position NAP noted. (2) facial grimacing. Attempted assiss inmate initially along w/ other staff in success. 1s 82 stated above. Dr. Rayapan called 1/10 given (1) Place inmate on stretcher & take to examine room & examine body. (2) Call me & report. Inmate lay rolled on mattress, Mattress placed on stretcher inmate transported to examine room. No visible signs. (3) Injury noted to back. (4) bruising noted.</p>	ORDERS / MEDICATIONS / IV FLUIDS		TIME	BY	
Report call to m.D. No given (1) Place in seg cell lying flat on back. (2) Remove all hazardous material. (3) will see in a.m.					
DIAGNOSIS					
INSTRUCTIONS TO PATIENT Lay flat on back.					
DISCHARGE DATE / /	TIME AM PM	RELEASE / TRANSFERRED TO <input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE	CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL		
NURSE'S SIGNATURE G. Massayh	DATE 12-5-05	PHYSICIAN'S SIGNATURE 	DATE	CONSULTATION	
INMATE NAME (LAST, FIRST, MIDDLE) Grafen Sidney			DOC# 224797	DOB 32374	R/S B/m
					FAC VCF



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Sydney Clayton Date of Request: 12/7/05
 ID # 224797 Date of Birth: 3/23/76 Location: Health Care
 Nature of problem or request: I need bottom bank profile, I need to review
Sharing profile, I need to see about bubble portions of food
I have lost about 167 of weight.

Sydney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 12/8/05
 Time: 12:25 AM PM
 Allergies: NKA -

RECEIVED
 Date: 12/8/05
 Time: 8:30
 Receiving Nurse Initials DS

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT: 190

See Det Tool

(A)sessment:

Sharing Profile reviewed & sig.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

J. Johnson

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Facility: VENTRESS	Sidney
Patient Name: Clayton	
Inmate Number: 224797	First Date of Birth: 3 12 31 74 MM DD YYYY
Date of Report: 12 18 05 MM DD YYYY	Time Seen: 12:25 AM / PM Circle One

Subjective: Chief Complaint(s): Bottom Burn, Boiling Pus, Double
Onset:

Brief History: will give double fatten feed. Spun
(Continue on back if necessary)
will give burn, Boiling pus will be addressed when I'm
discharged from Inf. Sec.

Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 80 RR: 20 B/P: 140 / 84

Examination Findings: will give burn, Boiling pus, Double
(Continue on back if necessary)
fatten and Boiling pus will be addressed by Dr. S.
no double fatten needed wt or VS within
normal limits.

Assessment: (Referral Status) Preliminary Determination(s): Comfort Attained.
 Referral NOT REQUIRED

Check Here if additional notes on back

- Referral REQUIRED due to the following: (Check all that apply)
 Recurrent Complaint (More than 2 visits for the same complaint)
 Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

- Instructions to return if condition worsens.
 Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: Removal

(Describe) _____

OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, Whom/Where): _____

Date for referral: / /

MM DD YYYY

Time _____

Referral Type: Routine Urgent Emergent (if emergent who was contacted?)

x J. Adams
Nurses Signature

Name: J. Adams RN

Printed



INFIRMARY NURSING PROGRESS NOTES

Date/Time	
12-7-05 7 ⁰⁰ am - S- I am about the same //	
① - w/s wt 188, P63 f20, B/Sat 96%, B/P 10/70 T96°, Ambulates c steady gait no % pain @ this time, consumed 100% hammed Off to see MD this am	After
12-7-05 9:35 - P/- Seen by Dr Pygati D/c'd to DOC/Beg, D/c'd from medical, D/Marsh	
3-7-06 P- Annual physical done - TB shot given	Bengfield J



Facility: VENTRESS

Patient Name: Clayton Sidney

Inmate Number: 224797

First Date of Birth: 3 23 76 MI

Date of Report: 12 14 05

Time Seen: 243 AM / PM Circle One

Subjective: Chief Complaint: "I'm dizzy" I ate all my food
Onset: I've been throwing up all day since breakfast
History: (12-3-05) Vomited last e 12:00 AM tonight
(Continue on back if necessary)
I just eat undigested food.

Pain Description: Sharp Dull Crampy Burning
 Intermittent Constant Radiation to:
 Other:

Check Here if additional notes on back
Location: RUQ LUQ
 RLQ LLQ
 Epigastric Diffuse

Last BM: Normal Constipation Diarrhea x stools Color change: No Yes

Associated symptoms: Nausea No Yes Vomiting No Yes (x 3) Painful urination: No Yes
Back pain No Yes Other: _____

* FEMALE: LMP: MM / DD / YYYY Vaginal Discharge: No Yes (Describe): _____

Pregnancy Test: negative / positive / NA (Circle One) * The possibility of pregnancy exists for any female of potential childbearing age unless a bilateral oophorectomy or hysterectomy has been performed

Objective: Vital Signs: (If Indicated) T: 98.9 P: 66 RR: 18 B/P: 120 / 77

General appearance: No acute distress Acute distress Unable to stand erect Knees drawn up

Skin: Warm Cool Dry Moist/clammy Skin Color: Normal Pallor Flushed Jaundice

Mucous Membranes: Moist Dry

ABDOMINAL EXAM

Bowel sounds: Present Decreased Absent

Abdomen: Soft Guarding Distended Non-Tender Tender all 4 quadrants

Location

Pain induced/increased with: Walking No Yes

Pain induced/increased with: Gentle abdominal palpation No Yes

Additional Examination: abdominal C10 pain in abd everywhere
Continue on back if necessary

Check Here if continued on back

Assessment: (Referral Status)

Preliminary Determination(s): _____

Referral Not Required

Referral Required due to the following: (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal Vital Signs | <input type="checkbox"/> Distended/rigid abdomen | <input type="checkbox"/> Persistent Nausea and/or vomiting |
| <input type="checkbox"/> Bloody or "Tarry" stools | <input type="checkbox"/> Pallor, moist clammy skin | <input type="checkbox"/> Recurrent Complaint (More than 2 visits for the same complaint) |
| <input type="checkbox"/> Other: | | |

You should contact a physician or nursing supervisor if you have any questions about the status of the patient.

Plan:

Check All That Apply:

Instructions to return if condition worsens or does not improve inform officer

Education on bowel elimination Education on Lifestyle Modifications to prevent reflux

Education The patient demonstrates an understanding of the nature of their medical condition and signs and symptoms for which they should seek additional medical attention. (Persistent vomiting, significant weakness, signs of dehydration, worsening abdominal pain, fever) as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

OTC Meds given Pepto-Bismol 10-15 cc PO X1 dose (or) Maalox 30 cc PO X1 dose

Other OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, Whom/Where): _____ Date for referral: / / MM DD YYYY

Referral Type: Routine Urgent Emergent (if emergent who was contacted?) Time _____

x D. Seal Jr. Name Dianne P. Seal

Nurses Signature

Printed



INFIRMARY NURSING PROGRESS NOTES

Date/Time	
12-6-05 2400	S "feel stee in pain" - 0 Lying on back on floor in severe resp. reg & unlabored abd soft B5+! Motor exts n commin Pedal Pulse + to + exts. B/p 110/70, 1898.4 80 skin wt d abd x 3. No acute distress A. Alt in comfort. R/H pain. P. Cont to observe. E. exist to call nurse for any problems or c/o.
12-6-05 0330	0 Tol 100% diet well ate break- fast in a) setting Positive. No nausea or vomiting noted. Resting 5 distress resp. reg & unlabored No distress noted.
12-6-05 0800	0 Lying on floor on mat on R. Side. Reacts to verbal. Wt. 186, BP 112/60, P60 T98 R20, Os 98. SpO2 Seen by Dr Rayapati - orders noted above Sitting up on mattress propped against wall No acute distress noted.
A) P)	Alt. Comfort R/T Back & Shoulder. Monitor/pwile meds.

INMATE NAME (LAST, FIRST, MIDDLE)

Gaylor, Sidney

DOC#

224797

DOB

3-23-74

R/S

B/m

FAC

VCF